Lake Pointe Pediatric Associates, P. A.

6900 Scenic Drive Suite 103 Rowlett Texas 75088 Telephone 972-412-1034 Fax 972-475-5708

Pamela M.M. Wieland, M.D. Dynal M. London, M.D.

Payment Terms for Services Rendered

I request that payment of authorized insurance benefits be made on my behalf to Lake Pointe Pediatric Associates (LPPA), P.A., Pamela Wieland, M.D. or Dynal London, M.D.

I authorize the release of medical or other information necessary to determine these benefits.

LPPA will attempt to verify my insurance benefits for the date of service. I understand that any co-payment, co-insurance, deductible or charge for non-covered services will be due on the date of service. If my insurance company's claim determination differs from the calculation by LPPA, the insurance company determination will govern. I will be responsible for any additional charges not collected on the date of service. I agree to pay any additional charges within 15 days of the date of the Explanation of Benefits (EOB) issued by my insurance company disclosing the additional charges. If the EOB indicates I have an account credit balance after all claims are processed, I may request the credit be applied to future services or request a refund. A refund check will be issued within 15 days of my written request.

I assume full responsibility to pay for any services rendered that are not paid for by insurance proceeds. If my insurance company should pay benefits directly to me for any services provided by LPPA I will endorse all checks from my insurance company over to LPPA or will pay LPPA directly by cash, check or credit card within 15 days of receiving a statement from LPPA.

I agree to reimburse Lake Pointe Pediatric Associates, P.A. for the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorneys' fees, LPPA incurs in such collection efforts.

I agree to notify LPPA immediately of any changes in my insurance coverage.

I understand that if my child is in for a well visit and he/she is found to be ill, or have other health issues that will result in significant additional work not directly related to a well visit, my insurance may not cover the additional charges. **In the event payment is denied, I agree to assume full responsibility for the additional charges.**

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Signature of Parent or Guardian Date

_____ _____

Child's Name Child's DOB